DOI: 10.1590/1413-81232017226.01532017

Health work: portrait of community workers in the Northeast region of Brazil

Paloma Ribeiro Pires Simas [1]
Isabela Cardoso de Matos Pinto [1]

Abstract *The aim of this study was to characterize the profile of community health workers in northeastern Brazil and aspects related to the management of their work. This is a cross-sectional study, which included 535 community agents who were distributed in 107 primary health units in northeastern Brazil. The data were extracted from eight blocks of questions related to the community agents' perceptions about social-demographic, economic and political factors; their contracts and remuneration; their evaluation as workers; their working conditions and their training. The results indicate that the majority of community agents in the northeast region were hired by direct administration. The main form of hiring community agents was by public exam, followed by public selection. Direct administration is the main form of hiring; however, new modalities, such as the public and private law foundations, social organizations, and inter-municipal consortiums are alternatives that have been adopted by managers which can produce a number of weaknesses due to flexible labor relations.*

Key words *Community health agents, Primary health care, Working conditions, Management of human resources in health*

[1] Instituto de Saúde Coletiva, Universidade Federal da Bahia. R. Basílio da Gama s/n, Canela. 40110-040 Salvador BA Brasil. paloma_simas@hotmail.com

Introduction

At the end of the twentieth century, the process of consolidation and implementation of the Unified Health System (SUS) in Brazil was marked by the recognition of the universal right to health, which was guaranteed in the Federal Constitution of 1988. Among the strategies that were adopted within this process, restructuring the health care model was particularly important, with primary care chosen to be the guiding axis and the priority model for organizing the Brazilian health system. The implantation of the Community Health Agents Program (PACS) and the Family Health Program (PSF), which was renamed as the Family Health Strategy in 1997, were health policies of national scope which led to important changes in Brazil[1,2].

The PACS was the first national strategy that was intended to strengthen health promotion and prevention actions developed both in patients' homes and at the local level[3]. The origin of the PACS, in 1987, was based on the successful example of female health agents in the Brazilian state of Ceará[3]; however, it was only instituted in 1991, when it was implemented by the Ministry of Health with the intention of reducing high infant and maternal mortality rates in the northeast of Brazil. It was subsequently expanded to cover states in the north of Brazil due to a public health emergency provoked by a cholera epidemic. The PACS contained intervention actions which were subsequently incorporated and developed by the PSF. These actions included the following: defining responsibility for a territory and assigning clients; focusing on health practices within the family and not on individuals; prioritizing preventive actions in the face of problems; integrating health services within the community; multi-professional teamwork; and, above all, the presence of a central element, which was designed as a key factor in the development of health actions – the creation of community health agents (CHAs)[4,5].

CHAs appeared on the health scene in Brazil as part of multi-professional teams within the Family Health Strategy and their responsibilities were defined by Ordinance No. 1,886/1997, which approved the norms and guidelines of the PACS/ PSF. However, the guidelines for CHA activities in Brazil were only consolidated after the publication of Decree No. 3189/1999. Recognition of CHAs as a profession occurred in 2002, with regulation through the enactment of Law No. 10,507/2002.

The role of the CHA is unique since they have a community identity and are the main mediators between the community and the other professionals working in health teams[6].

According to Ministry of Health data, in March 2016 the northeast region of Brazil had 102,655 CHAs working in rural communities and urban peripheries, as well as in highly urbanized and industrialized municipalities, providing population coverage of approximately 86.7%. This reveals the importance of CHAs, both in terms of increasing access to primary health services[7] and also in expanding the coverage of the Family Health Strategy in most of the municipalities throughout Brazil[3].

Several studies have highlighted CHAs as being central to the development of health actions[8,9], as well as discussing their responsibilities[10], work practices and processes[11-13], working conditions[14], professional training[15,16], health conditions[17], professional profile[18,19], and work management[20,21].

Although they are considered to be important professionals in terms of changing the Brazilian health care model, these workers are still subject to diverse work practices, which are expressed in new, flexible modes of hiring, contracts and remuneration, as well as the processes of training to be a CHA[22].

The lack of studies on aspects related to the management of the work of CHAs in Brazil makes it difficult to formulate and implement policies aimed at the evaluation of these workers, as well as strengthening primary health care. Thus, this study characterizes the profile of community health agents in the northeast of Brazil, as well as aspects related to their work, based on research regarding the evaluation of the profile of community health agents in relation to the process of consolidating primary health care in Brazil.

Theoretical-methodological procedures

In order to understand the characteristics of the work of CHAs, this study is based on the concepts of work, work management and working conditions as essential elements to be able to reflect on the value of health workers.

Work can be understood as a process that is inherent to human beings, consequently, it cannot be simply reduced to a paid activity or employment because it incorporates a number of elements that embrace both ideologies and the

Ciência & Saúde Coletiva, 22(6):1865-1876, 2017

necessities of life (social, cultural, and economic, for example)[22]. Thus, the ability to recreate oneself through work motivates individuals to seek means or ways of life that are capable of responding to their needs, highlighting work as one of the central characteristics of modern society[23,24].

Therefore, it is important to highlight the problems related to the world of work, as well as the public policies that are capable of responding to the needs of workers. In the area of health, the Basic Operational Standard for Human Resources in the Unified Health System (NOB/RH-SUS)[25] is particularly important, and it considers management within the SUS to be the "the management of any and all work relationships necessary for the functioning of the system; from the provision of direct care regarding the health of its users to the intermediate activities necessary for its development". Management within the SUS should coordinate work relations, favoring conditions for the production of quality activities, and promoting the improvement and humanization of the SUS's services to its users; recognizing the SUS workforce in order to improve its size, use, distribution and qualification.

In fact, the responsibility of the state in relation to the complexity of health work involves a number of aspects. On the one hand, there is the need to train workers to competently and skillfully assume their tasks in relation to the healthcare of the population, giving them security to carry out their work with motivation, as well as stimulating their capacity to act politically to ensure that the principles of the SUS are strengthened[26]. On the other hand, it is important to consider the issue of working conditions, whose effects, together with other factors, determine both the health of the individuals who operate the system and the means they have to fully exercise their capacities[27]. In terms of the latter, the worker's body becomes the main target for the occurrence of diseases associated with physical and mental exhaustion[28], driven by the capitalist mode of production, in which the health care workforce has been increasingly subjected to the introduction of technologies that have led to segmentation in professional training and the emergence of new categories of work[24]

Evidence of this can be seen in new forms of hiring, as well as trends in public administration that have increased flexibilization, outsourcing and job insecurity, all of which can be characterized as diluting social protection through fixed-term contracts, which provoke instability and vulnerability in the employment conditions of workers. This has resulted in the emergence of what can be considered to be a new social class in formation, i.e. those workers who have flexible terms of employment, who lack guarantees in the labor market, employment contracts, security in terms of employment, skill reproduction, security of income and the guarantee of representation[29,30].

Regarding this issue, Cordeiro[31] makes the point that the flexibilization of labor relations within the SUS has resulted in dissatisfaction and a decrease in commitment to the public by health workers, low self-esteem, the fragmentation of work and discontinuity in the provision of health actions, which are all linked to the increased incidence of the precariousness of employment. Koster[22] argues that this situation has had complex repercussion within the SUS, considering that a large part of the hiring of staff is performed illegally, which increases the challenges related to the management of work.

Methodological strategy

This study analyzes part of the results of a national study regarding the profile and practices of CHAs involved in consolidating primary health care in Brazil. The national study was performed by the Institute of Public Health/Federal University of Bahia, with funding from the Ministry of Health.

The present study is cross-sectional and the units of analysis were CHAs. The study population included 535 CHAs distributed in 107 primary health units in the northeast region of Brazil. The sampling process was carried out successively in stages, drawing lots to choose municipalities in the regions, followed by drawing lots to choose health units in municipalities and teams.

The northeast region included the nine self-represented capital cities, and twenty-seven municipalities were drawn by lots. All the CHAs of the family health teams working in the primary health units were interviewed, except those who were suspended, on holiday, on sick leave, on maternity leave, or were absent in the units. Initially, it was decided that six CHAs would be interviewed, selection being through the drawing of lots. However, because the number of CHAs in some units was lower than expected, this target was increased to up to eight CHAs per unit, in order to compensate for the number of interviews in units in which the number of CHAs was lower than expected. In cases where the number

of these professionals was less than eight, an interview was conducted with all those present at the primary health unit.

The data collection was performed through a questionnaire, which was applied through a face-to-face interview containing the following five modules: Module I - perceptions of service users; Module II - perceptions of CHA; Module III - perceptions of the manager/coordinator of primary healthcare; Module IV- perceptions of the instructor or supervisor of the CHA; Module V- perceptions of other professionals. For Module II, the following eight blocks were chosen regarding the CHA: profile (socio-demographic, economic and political data) and the management of work (mechanisms regarding hiring, remuneration, employee evaluation, working conditions and training).

Documentary analysis was also used because this study included ordinances, laws and decrees, as well as 14 selective process notices for hiring ACSs in municipalities throughout Brazil, in order to obtain information about the criteria required for the selection and hiring of CHAs.

Stata version 12.0 and Excel 2013 software were used for the data processing and analysis. In accordance with the norms set out in Resolution No. 466/2012 for research involving human beings, the present study was submitted to the Committee on Ethics in Research of the ISC-UFBA and was approved by Ruling No. 871,501 on 10/11/2014.

Results and discussion

Profile of community health agents

The 535 CHAs who were interviewed were distributed in 107 primary health units in the northeast region of Brazil. Of this total, 76.5% were female; 85.2% had children and 67.6% had completed high school. It was observed that the majority of the CHAs were female, which follows the tendency of other occupations in the area of health, and consequently the results of this study corroborate with other studies which also found that the majority of CHAs were female[32,33]. The level of education among the CHAs was higher than that required by Law No. 11,350/2006, which stipulates that, as a minimum, CHAs should have completed elementary education. This finding is in accordance with other studies that analyzed the level of education of CHAs, demonstrating that the majority of those who work in primary health care have elementary and secondary level education[18,26,32,33].

The mean age was 40.8 years (SD = 8.7), which also corroborated previous studies[34]. Regarding the issue of race/color, 66.2% of the CHAs self-identified as being mixed race (*parda*) (Table 1). In terms of marital status, 73.6% were married or had a partner, followed by those who were single (18.3%). This situation reflects the average number of children found in the 2010 census, which were 1.9 children.

Regarding the issue of religion, 65.4% declared themselves as being Catholic, which mirrored the findings of a previous study[32]. According to the authors of the aforementioned study, the issue of religiosity and health incorporates an historical-social context which that allows CHAs to have a greater interaction with the community in which they work, influencing the performance of their role and valuing their perceptions of individuals in the health-disease process.

The data showed that 69.7% of the CHAs received a salary equivalent to 1 - 1.5 minimum salaries (Table 1) and for 31.4% of them their salary as a CHA corresponded to the total family income; 37.0% of the CHAs stated that they depended on their partner's income to help pay for household expenses (Table 1).

The majority of the CHAs lived in their own property (78.9%), which is a higher percentage than the Brazilian average (71.6%). The presence of durable consumer goods at home reflects the possibility of acquiring items that are important for domestic daily life, as well as other items that are linked with changes in society, including the growth of the use of motorcycles for travel.

Regarding their links with the community, 84.5% of CHAs said that they lived in the area where they worked, which was in line with the criteria defined by Brazilian legislation[4,18,32]. Jardim and Lancman[35] argue that living and working in the same area means CHAs have a double role to play (that of being a community health agent and also being an individual) and that there is a lack of distancing between working and living in the same community. CHAs are considered to be the main link between the population and the health services, with responsibility for carrying out health promotion, prevention, follow-up and surveillance, as well as educational work[36].

Walking to work (63.2%) was considered to be a benefit due to the lack of necessity to use public or private transportation to arrive at work[36]. The selective process notices that were analyzed revealed that some municipalities of-

Ciência & Saúde Coletiva, 22(6):1865-1876, 2017

Table 1. Distribution of CHAs according to socio-demographic, economic and political profile, northeast region, Brazil, 2014.

Variable	Brazil		Northeast region	
	N	%	N	%
Gender				
Female	1270	83.2	409	76.5%
Male	256	16.8	126	23.6%
Race/Color				
White	507	33.2	109	20.1
Black	182	11.9	63	11.8
Mixed race	805	52.7	354	66.2
Education				
Incomplete elementary school	16	1.1	9	1.7
Complete elementary school	140	9.2	57	10.6
Complete high school	1083	71.0	362	67.7
Incomplete undergraduate course	93	6.1	25	4.7
Complete undergraduate course	194	12.7	82	15.3
Head of the family/person responsible for household				
CHA	487	31.9	198	37.0
Spouse or partner of CHA	253	16.6	82	15.3
CHA and spouse or partner (equally)	581	38.1	197	36.8
Father or mother of CHA	165	10.8	46	8.6
Nobody is head of the family/person responsible for household	19	1.2	5	0.9
Other person	19	1.2	7	1.3
Income of CHA				
Less than one minimum salary	241	15.8	91	17.0
1-1.5 minimum salaries	1122	73.5	373	69.7
More than 1.5 minimum salaries	115	7.5	47	8.8
More than 2 minimum salaries	43	2.8	22	2.1
Participation in any social mobilization activity or community group	537	35.2	249	46.5
Groups that the CHA participates in or has participated in during the last year				
Community association	241	44.9	125	50.2
Local health council	165	30.7	60	24.1
Municipal health council	130	24.2	57	22.9
District health council	22	4.1	11	4.4
Trade union	185	34.5	100	40.2
Associations of patients with specific diseases	93	17.3	35	14.1
National Movement of Health Agents	149	27.8	96	38.6
Federation of Community Health Agents	84	15.6	70	28.1
Political party	68	12.7	38	15.3
National Confederation of Community Agents	64	11.9	51	20.5
Collective Bargaining Table of the SUS	45	8.4	28	11.2
Church or religious activity	341	63.5	166	66.7
Other	119	22.2	65	26.1

fered transportation assistance to those workers who lived more than a kilometer from their workplace, who needed to use public transport to get to work, or who lived in neighboring municipalities, all of which being situations that might increase the possibility of non-compliance with the requirement of CHAs to live in the community where they worked.

Regarding the political participation of the CHAs in social mobilization spaces, there was evidence of significant participation in churches or religious activities (66.7%) (Table 1). In addition to these activities, the CHAs also mentioned community associations (50.2%) and trade unions (40.2%) as other participation spaces (Table 1). The data of the present study demonstrate a high participation of CHAs in the northeast region in collective situations, which differs from the findings of other studies conducted in the southern region of Brazil[14].

The management of the work of community health agents

Hiring and remunerations

With regard to the issue of hiring of staff, in the northeast region, 67% of CHAs were contracted by direct administration (Table 2). Although Law No. 12994/2014 prohibits the temporary or outsourced hiring of CHAs (except in situations provided for by law), hiring by foundations, civil society organizations of public interest, social organizations and inter-municipal consortia are some strategies that are still adopted by some municipalities to hire health professionals in some regions of Brazil[21,37].

CHAs are recognized as a professional category and they have access to labor benefits through the auspices of Law No. 10,507/2002. However, according to Theisen[38], this recognition may not be sufficient to guarantee these rights because CHAs experience multiple forms of hiring and heterogeneous work contracts. According to Conass[39], hiring mechanisms are heterogeneous within regions of Brazil, and even in states within the same region, due to the particularities of each location and the management model adopted by the three administrative spheres.

The present study found that the main methods of hiring CHAs in the health services were

Table 2. Distribution of CHAs in relation to hiring and remuneration, northeast region, Brazil, 2014.

Variable	Brazil		Northeast region	
	N	%	N	%
Hiring agent				
Direct administration	1005	65.8	341	63.7
Inter-municipal consortia	62	4.1	29	5.4
Public foundations	110	7.2	35	6.5
OS/OSCIP	35	2.3	2	0.4
Other(s)	83	5.4	30	5.6
Contract type				
CLT public employee	376	24.6	127	23.7
State public employee	793	52.0	350	65.4
Other(s)	259	17.0	21	3.9
Method of becoming a CHA				
Public contest	807	52.9	330	61.7
Public selection (simplified selective process)	591	38.7	177	33.1
Recommendation	73	4.8	16	3.0
Other	23	1.5	1	0.2
Time working as CHA				
Less than 1 year	167	10.9	18	3.4
2 - 5 years	357	23.4	52	9.7
6 - 10 years	360	23.6	106	19.8
11- 15 years	390	25.6	183	34.2
More than 16 years	252	16.5	176	32.9
Workload				
40 h per week	1474	96.6	518	96.8
20 - 30 hours per week	35	2.3	9	1.7
Experience in heath service before working as CHA	309	20.2	111	20.7

Source: 'Profile of CHAs in Brazil Project', 2014.

Ciência & Saúde Coletiva, 22(6):1865-1876, 2017

by public exam (61.7%), followed by public selection (33.1%) (Table 2). This differs from the findings of a study by Junqueira et al.[40], where 15.6% of managers used public exams and 40.0% used public selection to hire staff. In addition, 55.6% of the managers in the aforementioned study used interviews as an additional criterion for hiring CHAs in municipalities. Constitutional Amendment No. 51/2006 states that CHAs should be hired through a public selection process.

Regarding the types of contract, 65.4% of CHAs were statute employees in the northeast region, followed by CLT-regulated contracts (Table 2). However, a study by Junqueira et al.[40] revealed a high percentage of temporary contracts (75.6%).

Some authors have discussed the fragile and informal nature of employment contracts offered by municipalities, both before and after the promulgation of Constitutional Amendment No. 51/2006 and Law No. 11,350/2006, whose purpose was to reverse the illegal nature of contracts for CHAs in public services[41,42]. This fragility reflects the largely precariousness nature of labor relations in Brazil, which has favored the proliferation of deregulated employment contracts, precarious state contracts, as well as different forms of remuneration[43-45].

In relation to the employment contracts of the individual states in the northeast region, those with the highest percentages of statutory CHAs were Rio Grande do Norte (96.0%) and Pernambuco (90.0%) (Table 3).

Regarding the eligibility requirements to be employed as a CHA, 96.3% lived in the community where they worked, 88.6% were solely employed as a CHA and 68.2% had completed elementary education. It should be noted that 56.5% of the CHAs in the northeast region did not mention the initial training course as a minimum requirement for their hiring. According to Law No. 10,507/2002 and Order No. 243/2015, as well as being a requirement for the profession, the basic qualification course for the training of CHAs is also a teaching module for initial professional qualification to allow staff to perform the day-to-day activities of disease prevention and health promotion through individual, collective domiciliary or community actions.

Most of the CHAs who were interviewed (79.3%) reported having had no prior experience in the health services, a fact that may be associated with the educational criteria required by the primary health care policy, which only stipulates reading and writing skills, with no other professional qualifications required.

Regarding the different types of employment contracts, the present study found that they were heterogeneous, both in the manner of hiring (public tender, public selection, fixed-term contract) and also in relation to the diversity regarding remuneration, hiring, and number of hours worked.

It is worth noting that in some of the public exams that were analyzed, there were references to CHAs working in primary care services with 24-hour care, which contradicts what is foreseen in the National Primary Care Policy and also what is set out in the normative framework regarding CHAs, in which it is intended that these professionals should only participate in teams within the Family Health Strategy and the CHA program.

The evaluation of community health agents

Regarding the issue of the evaluation of CHAs, only 17.4% in the northeast region reported having a career plan including progression by professional qualification and training (Table 4). However, the states of Alagoas (63.9%) and Pernambuco (31.9%) presented the best results in this respect (Table 3). The majority of the participants in this research (63.2%) stated that their municipality had a career plan for the profession but they did not know the criteria for progression (Table 4).

In spite of the efforts of some municipal and state managers to implement policies intended to appreciate the work of CHAs, some states still lack career plans, including Bahia (79.3%), Paraíba (72.7%) and Maranhão (71.3%) (Table 3), which has a direct impact on the professional progression of CHAs in primary health care[45]. According to NOB/RH-SUS guidelines, the Positions, Careers and Salaries Plans (PCCS) are considered to be incorporated at each management level of the SUS[46].

This study found that 45% of CHAs were usually evaluated monthly by their team or by municipal management and only 24.9% received incentives, bonuses or financial rewards for their performance. Decree No. 7,133/2010 regulates the criteria and procedures for conducting evaluations and the payment of performance bonuses; it states that such payments are based on the achievement of goals, productivity, teamwork and the knowledge and techniques required to perform activities in accordance with the position in question.

Table 3. Distribution of CHAs according to career plan and employment contract by federal units in northeast region, Brazil, 2014.

Variable	Federal units									
	Northeast Region		Alagoas		Bahia		Ceará		Maranhão	
	N	%	N	%	N	%	N	%	N	%
Career Plan										
Yes, with progression by qualification and professional training	93	17.4	23	63.9	5	4.7	9	11.1	7	8.8
Yes, without progression by qualification and professional training	10	1.9	-	-	-	-	3	3.7	-	-
Yes, but did not know/refused to answer if there was progression by qualification and professional training	7	1.3	-	-	-	-	2	2.5	1	1.3
No career plan	338	63.2	10	27.8	84	79.3	45	55.6	57	71.3
Contract										
CLT public employee	127	23.7	7	19.4	29	27.4	13	16.1	20	25.0
State public employee	350	65.4	25	69.4	63	59.4	49	60.5	52	65.0
Other (s)	21	3.9	3	8.3	1	0.9	10	12.4	1	1.25

Variable	Federal units									
	Paraíba		Pernambuco		Piauí		Rio Grande do Norte		Sergipe	
	N	%	N	%	N	%	N	%	N	%
Career Plan										
Yes, with progression by qualification and professional training	1	3.0	29	31.9	7	14.0	4	15.4	8	25.0
Yes, without progression by qualification and professional training	-	-	4	4.4	2	4.0	1	3.9	-	-
Yes, but did not know/refused to answer if there was progression by qualification and professional training	-	-	1	1.1	1	2.0	2	7.7	-	-
No career plan	24	72.7	48	52.8	34	68.0	14	53.9	22	68.8
Contract										
CLT public employee	16	48.5	3	3.3	33	66.0	-	-	6	18.8
State public employee	15	45.5	82	90.1	13	26.0	25	96.2	26	81.3
Other (s)	1	3.0	3	3.3	2	4.0	-	-	-	-

Source: 'Profile of CHAs in Brazil Project', 2014.

Regarding the respect for and evaluation of CHAs by other professionals in their teams, 60.2% felt respected and 66.0% had their work recognized and valued (Table 4). Ferreira et al.[11] consider that the horizontal power of CHAs in relation to other professionals in their teams during home visits permits the creation of affections, thereby increasing the sharing of care management by the team.

Working conditions

In the present study, CHAs stated they were 80.0% satisfied with their place of work. This satisfaction may be related to the recognition and appreciation that they receive from their health team and from the community[6]. Brand et al[47] found that CHAs felt extremely satisfied and valued when they received attention or were heard by the community, i.e. when they were able to provoke some positive change that directly reflected on the quality of care provided.

Table 4. Distribution of CHAs in terms of workplace evaluation, northeast region, Brazil, 2014.

Variable	Brazil		Northeast region	
	N	%	N	%
Career plan				
Yes, with progression by qualification and professional training	171	11.2	93	17.4
Yes, without progression by qualification and professional training	42	2.7	10	1.9
Yes, but did not know/failed to state whether by qualification and professional training	1017	66.6	338	63.2
Evaluation by the team and/or municipal management	940	61.6	333	62.2
Frequency of evaluation				
At least twice a month	146	15.5	51	15.3
Monthly	295	31.4	150	45.0
At least twice a year	129	13.7	23	6.9
Yearly	148	15.7	30	9.0
No defined period	179	19.0	67	20.1
Receive some kind of incentive, bonus or financial reward for performance	350	22.9	133	24.9
Feel respected by the other professionals who make up the family health team	974	63.8	322	60.2
Appreciation and recognition of work by other professionals who make up the family health team	923	68.6	314	66.0

Source: Profile of CHAs in Brazil Project', 2014.

The mean number of families that were attended to by the CHAs was 139.1 (SD = 58.8) and the number of people within those families was 509.6 (SD = 213.2). Both of these figures are within the values recommended by the Ministry of Health, which state that the number of CHAs should be sufficient to cover 100% of the registered population, with a maximum number of 750 people per CHA[48]. These data are consistent with a study by Simões[49], in which the number of families attended by CHAs in the studied city was 151 for 200 families, but the data in the present study contradicts other studies, in which the overload of work of CHAs was directly related to the high number of families under their responsibility[7,34].

The Ministry of Health has defined uniforms, ID badges, primary health information system files, weighing scales, a stopwatch, a thermometer, a tape measure and educational material as basic equipment for the work of the CHAs[37]. The present study found that a registration form (94.2%), materials to measure and weigh (64.1%), and a map of the territory (62.2%) were the main items of equipment available for CHAs in the northeast. Other indispensable materials, such as protective masks and sunscreen, were not available[15]. A study by Lima et al.[50] found that most of the interviewees were exposed to the sun for more than five hours a day at critical times between 10 am and 3 pm, posing a high risk to health. The lack of legislation requiring institutions to provide sunscreen for workers contributes to the increased risk of cancer due to continued ultraviolet exposure[50].

Regarding their choice of profession, the main reason cited by the interviewees in the present study was the employment opportunity (30.3%), which was in agreement with other study[51].

It should be noted that 23.9% of the CHAs reported that they had another paid activity outside of working hours, which may have influenced the performance of their duties as a CHA in some way, either through the accumulation of hours or through physical exertion.

Training processes

The issue of training has been discussed by several authors, who have examined perspectives, questions and criticisms regarding the origin and development of the training process for CHAs. In the present study, 89.0% of respondents reported having attended an initial training course, which differed from Santos's et al. study[18], in which CHAs did not experience introductory training.

The recognition of the profession, as well as the incorporation of CHAs in multi-professional teams, were elements that motivated the Ministry

of Health to delineate the training processes and the professional profile of CHAs. Thus, in 2004 the curricular reference of the technical course for CHAs was instituted, with the purpose of aiding training institutions to prepare their professionalization programs.

The aforementioned document sets out the details of the technical course, with a minimum workload of 1,200 hours, in compliance with Resolution No. 4/1999 of the Education Council. The latter body established the National Curricular Guidelines for Vocational Education at the Technical Level[52], defining its curricular structure in the following three stages: a) initial training and social profile of the community health agent and their role within the multi-professional team; b) the development of competencies in the field of health promotion and disease prevention, targeting individuals, specific groups and prevalent diseases; and c) the development of competences in relation to the promotion, prevention and monitoring of situations of environmental and sanitary risk. Some authors have identified an inherent problem in guaranteeing the complete technical training of the course, including all its three stages at the national level, because once these workers became qualified technicians they could claim wage increases[52].

In terms of professional qualifications, it was found that 34.2% of the respondents stated that they had other types of health education, particularly auxiliary and technical courses in nursing. It is also worth mentioning that a small percentage of CHAs had passed a higher education course in health. These results are in agreement with the findings of a study by Marzari et al.[19], in which CHAs were identified as workers seeking alternatives to schooling and professional training.

Admission to the CHA profession provides access to new knowledge through the skills required to perform the job. The present study found a high percentage of participation in courses after CHAs started working in family health teams. Of the topics that were cited, the most mentioned were as follows: specific programs (91.7%); health promotion (92.5%); oral health (79.2%); and territorial organization (68.3%).

These findings reflect the investment by health secretariats in refresher courses aimed at meeting the training needs of CHAs in carrying out their daily work within the community. However, this training cannot happen in an isolated and decontextualized way[19]. In this context, some authors have stressed the importance of the preparation and performance of training processes that are based on biomedical references, contradicting the idea of reorientating the attention model, in which health actions directed towards populations should be based on the promotion and protection of health, as well as disease prevention. Training processes should be devised in an integral way that impacts on the determining and constraining factors regarding the health of communities[48,52].

Final considerations

The results of this study made it possible to discuss aspects related to the management of the work of community health agents in the northeast region of Brazil. The hiring of CHAs takes place through public exams and public selection, which result in situations of greater stability for workers and the guarantee of labor rights. It is important to emphasize the efforts made to improve employment contracts in the northeastern states, where the majority of CHAs are in a regulated situation. The findings of this study reveal that career plans do exist for these professionals; however, many CHAs are unaware of the criteria and characteristics of the career plans to which they are linked.

The search for qualifications at both the technical and higher levels has triggered changes in the training profile of CHAs, as well as being a means of demonstrating the appreciation and recognition of these professionals by their team and by the community. The themes of the training courses still reinforce the biomedical paradigm, highlighting an insufficiency in the training processes, which that are based on the debate regarding SUS health policies and health promotion practices.

Finally, it is important to highlight political movements, an example of which was the mobilization of CHAs in response to the recent publication of Decree No. 958/2016 by the Ministry of Health which suggested the possibility of a change in the composition of primary health care teams. The immediate action by CHAs led to the annulment of the aforementioned decree, preventing setbacks in relation to the management of the work of CHAs, and consequently, the weakening of primary health care in Brazil.

Collaborations

PRP Simas and ICM Pinto participated equally in all stages of preparing this article.

Acknowledgments

The authors would like to thanks the following: the community health agents for the welcome they provided in their workspaces and also their availability to contribute to the research; the members of the 'Profile of CHAs in Brazil' project team for their competence and dedication during the time of the research; the municipal managers who agreed to participate in this study; and SGTES/MS for funding this study.

References

1. Aquino R, Medina MG, Vilasbôas ALQ, Barreto ML. Programa de Saúde da Família: análise de sua implantação no Brasil. In: Silva LR, organizador. *Diagnóstico em pediatria*. Rio de Janeiro: Guanabara Koogan; 2009. p. 1031-1040.
2. Aquino R, Medina MG, Nunes CA, Sousa MF. A Estratégia Saúde da Família e o reordenamento do sistema de serviços de saúde. In: Paim J, Almeida-Filho N, organizadores. *Saúde Coletiva: Teoria e Prática*. Rio de Janeiro: Editora MedBooks; 2013. p. 353-371.
3. Ávila MMM. O Programa de Agentes Comunitários de Saúde no Ceará: o caso de Uruburetama. *Cien Saude Colet* 2011; 16(1):349-360.
4. Brasil. Ministério da Saúde (MS). Portaria no. 1886/GM, de 18 de dezembro de 1997. Aprova as Normas e Diretrizes do Programa de Agentes Comunitários de Saúde. *Diário Oficial da União* 1997; 19 dez.
5. Brasil. Ministério da Saúde (MS). *Saúde da Família - uma estratégia para a reorientação do modelo assistencial*. Brasília: MS; 1997.
6. Costa MC, Silva EB, Jahn AC, Resta DG, Colom ICS, Carli R. Processo de trabalho dos agentes comunitários de saúde: possibilidades e limites. *Rev. Gaúcha Enferm* 2012; 33(3):134-140.
7. Gomes KO, Cotta RMM, Cherchiglia ML, Mitre SM, Batista RS. A práxis do agente comunitário de saúde no contexto do programa saúde da família: reflexões estratégicas. *Saude soc* 2009; 18(4):744-755.
8. Filgueiras AS, Silva ALA. Agente Comunitário de Saúde: um novo ator no cenário da saúde do Brasil. *Physis* 2011; 21(3):899-916.
9. Costa SM, Araújo FF, Rodrigues CAQ, Araújo FM, Nobre LLR, Martins LV. Agente Comunitário de Saúde: elemento nuclear das ações em saúde. *Cien Saude Colet* 2013; 18(7):2147-2156.
10. Silva JA, Dalmaso ASW. O agente comunitário de saúde e suas atribuições: os desafios para os processos de formação de recursos humanos em saúde. *Interface (Botucatu)* 2002; 6(10):75-83.
11. Ferreira VSC, Andrade CS, Franco TB, Merhy EE. Processo de trabalho do agente comunitário de saúde e a reestruturação produtiva. *Cad Saude Publica* 2009; 25(4):898-906.
12. Galavote HS, Prado TN, Maciel ELN, Lima RCD. Desvendando os processos de trabalho do agente comunitário de saúde nos cenários revelados na Estratégia Saúde da Família no município de Vitória (ES, Brasil). *Cien Saude Colet* 2011; 16(1):231-240.
13. Morosini MVGC. O agente comunitário de saúde: práticas educativas. *Trabalho, educação e Saúde* 2012; 10(2):347-348.
14. Silva CA, Rocha IQ, Siqueira MCG, Modesto MSA, Silva FP, Costa AMF. Formação técnica do agente comunitário de saúde: desafios e conquistas da Escola Técnica de Saúde do Tocantins. *Trabalho, Educação e Saúde* 2009; 7(3):609-621.
15. Marteleto RM, David HMSL. Almanaque do Agente Comunitário de Saúde: uma experiência de produção compartilhada de conhecimentos. *Interface (Botucatu)* 2014; 18(Supl. 2):1211-1226.
16. Gouvêa GR, Silva MAV, Pereira AC, Mialhe FL, Cortellazzi KL, Guerra LM. Avaliação do conhecimento em saúde bucal de agentes comunitários de saúde vinculados à Estratégia Saúde da Família. *Cien Saude Colet* 2015; 20(4):1185-1197.
17. Kluthcovsky ACGC, Takayanagui AMM, Santos CB, Kluthcovsky FA. Avaliação da qualidade de vida geral de agentes comunitários de saúde: a contribuição relativa das variáveis sociodemográficas e dos domínios da qualidade de vida. *Rev. psiquiatr. Rio Gd. Sul* 2007; 29(2):176-183.
18. Santos KT, Saliba NA, Moimaz SAS, Arcieri RM, Carvalho ML. Agente comunitário de saúde: perfil adequado a realidade do Programa Saúde da Família. *Cien Saude Colet* 2011; 16(Supl. 1):1023-1028.
19. Marzari CK, Junges JR, Selli L. Agentes comunitários de saúde: perfil e formação. *Cien Saude Colet* 2011; 16(Supl. 1):873-880.
20. Queirós AAL, Lima LP. A institucionalização do trabalho do agente comunitário de saúde. *Trabalho, Educação e Saúde* 2012; 10(2):257-281.
21. Carneiro CCG, Martins MIC. Novos modelos de gestão do trabalho no setor público de saúde e o trabalho do agente comunitário de saúde. *Trabalho, Educação e Saúde* 2015; 13(1):45-66.

22. Koster I. A *Gestão do Trabalho e o contexto da flexibilização no Sistema Único de Saúde* [dissertação]. Rio de Janeiro: Fundação Oswaldo Cruz; 2008.
23. Frigotto G. Trabalho. In: Pereira IB, Lima JCF, organizadores. *Dicionário da educação profissional em saúde*. Rio de Janeiro: EPSJV; 2008. p. 399.
24. Machado MH, Vieira ALS, Oliveira E. Gestão, trabalho e educação em saúde: perspectivas teórico metodólogicas. In: Baptista TWF, organizadora. *Politicas, Planejamento e gestão em saúde. Abordagens e métodos de pesquisa*. Rio de Janeiro: Editora Fiocruz; 2015. p. 292-317.
25. Brasil. Ministério da Saúde (MS). Conselho Nacional de Saúde. *Princípios e diretrizes para a gestão do trabalho no SUS (NOB/RH-SUS)*. Brasília: MS; 2005.
26. Rizzotto MLF, Gil CRR, Carvalho M, Fonseca ALN, Santos MF. Força de trabalho e gestão do trabalho em saúde: revelações da Avaliação Externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica no Paraná. *Saúde Debate* 2014; 38(n. esp.):237-251.
27. Ávila AA, Belisário SA, organizadoras. *Condições de trabalho e saúde dos trabalhadores da saúde*. Belo Horizonte: Nescon; 2007.
28. Dejour C, Abdoucheli E, Jayet C. *Psicodinâmica do trabalho, contribuições da Escola Dejouriana à análise da relação prazer, sofrimento e trabalho*. São Paulo: Atlas; 2014.
29. Nogueira RP, Baraldi S, Rodrigues VA. *Limites Críticos das Noções de Precariedade e Desprecarização do Trabalho na Administração Pública*. Brasília: UnB; 2004.
30. Standing G. *O precariado: A nova classe perigosa*. Belo Horizonte: Editora Autêntica; 2015.
31. Cordeiro H. Descentralização, universalidade e eqüidade nas reformas da saúde. *Cien Saude Colet* 2001; 6(2):319-328.
32. Lino MM, Lanzoni GMM, Albuquerque GL. Perfil Socioeconômico, demográfico e de trabalho dos Agentes Comunitários de Saúde. *Cogitare Enfermagem* 2012; 7(1):57-56
33. Musse JO, Santos SC, Marques RS, Lopes FRL, Monteiro KS. Avaliação de competências de Agentes Comunitários de Saúde para coleta de dados epidemiológicos. *Cien Saude Colet* 2015; 20(2):525-536.
34. Ferraz L, Aerts DRGC. O cotidiano de trabalho do agente comunitário de saúde no PSF em Porto Alegre. *Cien Saude Colet* 2005; 10(2):347-355.
35. Jardim TA, Lancman S. Aspectos subjetivos do morar e trabalhar na mesma comunidade: a realidade vivenciada pelo agente comunitário de saúde. *Interface (Botucatu)* 2009; 13(28):123-135.
36. Menegussi JM, Ogata MN, Rosalini MHP. O agente comunitário de saúde como morador, trabalhador e usuário em São Carlos, São Paulo. *Trabalho, educação e saúde* 2014; 12(1):87-106.
37. Brasil. Ministério da Saúde (MS). Secretaria de Políticas de Saúde. Departamento de Atenção Básica. *Modalidade de contratação de agentes comunitários de saúde: um pacto tripartite*. Brasília: MS; 2002.
38. Theisen NIS. *Agentes Comunitários de Saúde (ACS): Condições de Trabalho e Sofrimento Psíquico* [dissertação]. Santa Cruz do Sul: Universidade de Santa Cruz do Sul; 2004.
39. Brasil. Conselho Nacional de Secretários de Saúde (Conass). *Gestão do Trabalho na Saúde*. Brasília: Conass; 2007.
40. Junqueira TS, Cotta RMM, Gomes RC, Silveira SFR, Siqueira-Batista R, Pinheiro TMM, Sampaio RF. As relações laborais no âmbito da municipalização da gestão em saúde e os dilemas da relação expansão/precarização do trabalho no contexto do SUS. *Cad Saude Publica* 2010; 26(5):918-928.
41. Nascimento CMB. *Precarização do trabalho do Agente Comunitário de Saúde: um estudo em municípios da região metropolitana do Recife* [dissertação]. Recife: Fundação Oswaldo Cruz; 2005.
42. Cotta RMM, Schott M, Azeredo CM, Franceschini SCC, Priore SE, Dias G. Organização do trabalho e perfil dos profissionais do Programa Saúde da Família: um desafio na reestruturação da atenção básica em saúde. *Epidemiol. Serv. Saúde* 2006; 15(3):7-18.
43. Magalhães AGA. *Precarização do trabalho: reflexos e impactos na política de saúde brasileira*. In: Anais da VIII jornada internacional de políticas públicas, 2015, Maranhão, p.12.
44. Pierantoni CR. As reformas do Estado, da saúde e recursos humanos: limites e possibilidades. *Cien Saude Colet* 2001; 6(2):341-360.
45. Seidl H, Vieira SP, Fausto MCR, Lima RCD, Gagno J. Gestão do trabalho na Atenção Básica em Saúde: uma análise a partir da perspectiva das equipes participantes do PMAQ-AB. *Saúde debate* 2014; 38(n. spe):94-108.
46. Pierantoni C, Varella T, França T. Recursos humanos e gestão do trabalho em saúde: da teoria para a prática. In: Falcão A, Santos Neto PM, Costa PS, Belisário AS, organizadores. *Observatório de recursos humanos em saúde no Brasil: estudos e análises*. Brasília: Ministério da Saúde; 2004. p. 51-70.
47. Brand CI, Antunes RM, Fontana RT. Satisfações e insatisfações no trabalho do agente comunitário de saúde. *Cogitare Enferm* 2010; 15(1):40-47.
48. Brasil. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Diário Oficial da União 2011; 22 out.
49. Simões AR. O agente comunitário de saúde na equipe de saúde da família: fatores de sobrecarga de trabalho e estresse. *Rev Saúde Públ*. 2009; 2(1):6-21
50. Lima AG, Silva AMM, Soares CEC, Souza RAX, Souza MCR. Fotoexposição solar e fotoproteção de agentes de saúde em município de Minas Gerais. *Rev. Eletr. Enf.* 2010; 12(3):478-482.
51. Barcellos CSN, Pandolfi M, Miotto MHMB. Perfil do Agente Comunitário de Saúde (ACS) de Vitória - ES. *Rev Odontologia* 2006; 8(1):21-28.
52. Bornstein VJ, David HMSL. Contribuições da formação técnica do agente comunitário de saúde para o desenvolvimento do trabalho da equipe Saúde da Família. *Trab. educ. saúde* 2014; 12(1):107-128.

Article submitted 1/9/2016
Approved 11/3/2017
Final version submitted 13/3/2017